CREDIT CARD POLICY

Client Name:_____ Date of Birth:_____

Effective January 1, 2016 this office has requested that all clients complete a form authorizing me to keep a valid credit card number on file. **ALL CLIENTS ARE REQUIRED TO COMPLETE THIS FORM.** This form will be kept strictly confidential. My billing service will continue to process insurance claims and all co-pays and deductibles are due at the time of your appointment.

Your credit card will be charged **ONLY** under the following circumstances:

1. If there is a balance on your account after the insurance company pays their portion. An invoice will be sent one time. If the balance is not paid within 30 days the amount due will be posted to your credit card and you will be sent a receipt. If a second bill is required there will be a $5.00 re-billing fee. This notice serves as your consent to being charged for all client balances on your account.

2. If you miss your scheduled appointment without giving 24 hours notice to cancel or reschedule.

ACKNOWLEDGED, AGREED AND ACCEPTED:

My signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the circumstances listed above.

Client Signature:_____ Date: _____
(Or person authorized to sign for client)

NAME AS IT APPEARS ON CREDIT CARD:_____

BILLING ADDRESS:_____

PHONE NUMBER:_____ CELL _____

CARD TYPE:_____

NUMBER:_____

EXPIRATION DATE:_____ SECURITY CODE:_____